STATE OF MICHIGAN

DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of the Ambulatory Surgical Facilities Remedial Provider Class Plan Determination Report pursuant to Public Act 350 of 1980

_____/ No. 10-045-BC

Issued and entered
This 7th day of July, 2010
by Ken Ross
Commissioner

ORDER DETERMINING GOAL ACHIEVEMENT OF BLUE CROSS BLUE SHIELD OF MICHIGAN AMBULATORY SURGICAL FACILITY REMEDIAL PROVIDER CLASS PLAN

BACKGROUND

On January 15, 2009, the Commissioner issued Order No. 09-001-BC. This order provided written notice to Blue Cross Blue Shield of Michigan (BCBSM), health care providers and other interested parties of his intent to make a determination with respect to the Ambulatory Surgical Facility (ASF) Provider Class Plan. The purpose of the review was to determine whether BCBSM met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act (Act) for calendar years 2006 and 2007. Order No. 09-001-BC also called for persons to submit comments regarding the ASF Provider Class Plan to the Office of Financial and Insurance Regulation (OFIR) in accordance with Section 505(2) of the Act. Interested parties were given sixty days to prepare and submit written comments with regard to the ASF Provider Class Plan.

In an Order dated October 12, 2009, the Commissioner determined that the ASF plan had failed the quality and cost goals set forth in the Act and required BCBSM to rewrite the plan pursuant to Section 510(1)(c) of the Act. In accordance with Section 511(1) of the Act, BCBSM had six months to redraft the ASF Provider Class Plan, which was to include obtaining advice and consultation from providers and subscribers, using procedures established pursuant to Section 505.

OFIR received BCBSM's ASF Remedial Provider Class Plan on April 8, 2010. On April 9, 2010, OFIR sent all interested parties a copy of the remedial provider class plan and accepted written advice and consultation with respect to the remedial plan, through May 12, 2010, as required by Section 513(3) of the Act. While, as part of the review process, the Commissioner acknowledges and considers the comments received from interested parties, the Commissioner draws his conclusions based on the totality of the information available.

Section 513(1) of the Act requires the Commissioner to take no more than 90 days to examine the plan and determine if the plan submitted by BCBSM on April 8, 2010 substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner in his order of October 12, 2009.

DISCUSSION

Section 504(1) of the Act requires, in pertinent part, a health corporation to "contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services." In the Commissioner's October 12, 2009 determination report, although the access goal was met, BCBSM was found not to have met the quality and cost goals in its Ambulatory Surgical Facility Provider Class Plan. In the remedial plan filed on April 8, 2010, all three elements were again reviewed to determine whether they met all the applicable statutory requirements.

ACCESS GOAL

The October 12, 2009 determination report found that BCBSM achieved this goal which states "there will be an appropriate number of providers through this state to assure the availability of certificate covered health care services to each subscriber." After review of the remedial plan, the Commissioner concludes that the ASF remedial plan should continue to achieve the access goal.

Providers assert that BCBSM's Evidence of Need (EON) requirements are redundant, arduous and unnecessary. ASF providers believe that a facility that has met the State of Michigan Certificate of Need (CON) process should not also be subject to BCBSM's EON requirement. BCBSM states that the CON process is a prospective process as based on pledges from physicians regarding the number of cases they expect to perform in an ASF. BCBSM developed its EON requirement, which is a retrospective process, to require ASFs to provide evidence that they are indeed meeting their CON commitments. Under the EON process, a facility must demonstrate it is meeting its CON commitment over a minimum period of time (four months). BCBSM contends the EON process takes

up where the CON process leaves off and verifies that there is an actual need for an ASF.

BCBSM states that since its implementation of the EON process in 2000, several modifications have been made to the EON requirement in response to ASF providers' request for flexibility. These changes include reducing the minimum reporting period from six months to four months, recognizing dedicated endoscopy rooms, eliminating the single-specialty distinction, reducing the number of operating rooms, allowing ASFs to temporarily disable an operating room, expanding the definition of rural, and increasing the market share adjustment factor for new ASF applicant facilities. Despite the assertions made by some ASFs that the EON process limits access to care, there has been a significant increase in the number of approved facilities over a ten year period – from 21 in 2000 to 87 currently. Five facilities have received EON approval already in 2010.

The Surgery Center of Michigan suggested BCBSM eliminate the use of a "flat" EON case volume requirement and replace it with a regional-specific case volume requirement. BCBSM states that its market share adjustment factor applied to the EON volume requirement was initially regional-specific, ranging between 18% and 30%. In 2005, in response to provider input, this adjustment factor was increased to 30% for all regions in the Lower Peninsula and 40% in the Upper Peninsula.

The Surgery Center of Kalamazoo stated that the elimination of EON would provide cost savings to BCBSM through lower reimbursement rates. BCBSM states that its base fees for outpatient surgeries are the same in both the hospital and ASF setting. BCBSM acknowledges that some hospitals get additional amounts added to their outpatient reimbursement rates for costs unique to the hospital, such as graduate medical education and the cost of being available 24 hours a day, seven days a week to all patients. These particular costs exist even when procedures are shifted to the ASF setting. Thus, BCBSM contends that moving more outpatient surgical procedures from the hospital setting to the ASF setting will not result in cost savings to BCBSM.

Further, whereas ASF providers have significantly increased the number of operating rooms available to physicians and Michigan residents, there is no evidence that ASFs address a lack of access to care. BCBSM notes that new ASFs are most likely to be located in areas of the state where operating rooms are already plentiful.

ASF providers also expressed concern about subscriber liability. Subscriber liability levels are determined by BCBSM's customers, not BCBSM. Although each BCBSM member's copayment and deductible obligations are not the

responsibility of BCBSM, BCBSM states it does recognize the impact of higher subscriber liabilities on all providers and is looking into the matter. BCBSM is striving to address this issue in various ways and working on educating both subscribers and providers about this issue. BCBSM is implementing a pilot program to provide more specific payment information and facilitate payment prior to a procedure. At least one ASF provider has been invited to participate in this pilot program. BCBSM is also working to educate providers on their ability to collect payment prior to rendering a procedure.

ASF providers have suggested BCBSM cancel or suspend a member's coverage until the member has paid the provider all required copayments and deductibles. BCBSM states that it has explained to ASFs that state and federal law prohibit BCBSM from cancelling or suspending a member's coverage when they fail to pay their required copayments and deductibles. The guaranteed renewability provisions in Section 401e of the Act clearly state that BCBSM may only refuse to renew or continue coverage in the cases of fraud, intentional misrepresentation of material fact, failure to pay premium, or where BCBSM no longer offers a particular type of coverage in the market or where the member or the group move outside BCBSM's service area. Section 401(3)(a) of the Act also prohibits BCBSM from refusing to continue a certificate except where the member is serving a criminal sentence for defrauding BCBSM or is satisfying a civil judgment or paying BCBSM restitution pursuant to a voluntary agreement.

BCBSM notes that rescission of coverage for failure to pay cost sharing is also prohibited under the Patient Protection and Affordable Care Act, which in Section 2712 prohibits carriers from rescinding coverage except in cases of fraud or where the member has made a material misrepresentation of material fact as prohibited under the terms of the plan.

QUALITY GOAL

The October 12, 2009 determination report found that BCBSM failed to meet this goal, which requires that providers will meet and abide by reasonable standards of health care quality. Factors underlying this determination included BCBSM's failure to meet with the ASF Liaison Committee at least semi-annually as required by the ASF provider class plan previously approved by the Commissioner and its failure to assure that the work of the ASF Liaison Committee had validity so that it served as a vehicle of enhanced communication. BCBSM also failed to meet one of its own objectives by not having developed a method in which to assess BCBSM member satisfaction with ASF services. After review of the ASF remedial plan, the Commissioner concludes that the remedial plan substantially overcomes the deficiencies found in the October 12, 2009 determination report and now achieves this goal.

A few ASF providers indicated that the ASF Liaison Committee is a committee in name only. These ASF providers believe that the liaison committee is a forum for negotiation. The Act requires BCBSM obtain provider and subscriber input whenever it creates or modifies a provider class plan. The Act, however, tacitly recognizes that BCBSM obtain input but does not mandate that BCBSM adopt all provider and subscriber input received.

BCBSM's ASF Liaison Committee was created as an input forum to give ASFs the opportunity to provide non-binding input and recommendations on issues and activities related to the ASF Provider Class Plan. Specific responsibilities of the committee include:

- Initiating discussions to improve the administration of the ASF program
- Identifying potential resolutions for identified conflicts
- Providing early feedback and obtaining input regarding potential program changes
- Identifying public policy issues affecting ASF providers
- Furthering the relationship between BCBSM and participating ASF providers

BCBSM states it has made several changes over the last two years to the administration of the ASF Provider Class Plan based on the input received from the committee. These changes include:

- Removing the policy restriction on DME storage in the ASF (Note: this was approved by BCBSM internally in May 2010. An announcement to facilities is pending)
- Modifying EON requirements (2003 and 2008)
- Forming a quality subgroup and identifying quality measures to be posted on BCBSM's website (implementation pending)
- Increasing reimbursement for implant-related procedures (January 2009)
- Reviewing and modifying the outpatient surgery fee schedule to eliminate inequities across procedures on a budget neutral basis (ongoing)

BCBSM states that it was the providers on the ASF Liaison Committee who noted that the fee schedule was not balanced, with some procedures paying too much and some not enough. ASF providers suggested BCBSM reduce the overpayments and increase the underpayments. BCBSM states that significant modifications have been made based on the input received even though the committee is not a negotiating forum and the Act does not require BCBSM to seek the committee's approval to finalize reimbursement rates.

BCBSM states it modified its accreditation requirement to recognize a one-year term under the Accreditation Association for Ambulatory Health Care (AAAHC) Early Option survey program. This particular issue was raised by an ASF provider who is not on the ASF Liaison Committee but this matter was discussed with the group and further demonstrates BCBSM's willingness to respond to issues of concern to ASFs.

In its remedial plan, BCBSM sets forth its commitment to meet at least semi-annually with the ASF Liaison Committee. The remedial plan also strengthens the objectives of the ASF Liaison Committee to enhance the validity of the committee to ensure the committee serves as a vehicle of enhanced communication between BCBSM and ASF providers. Lastly, to comply with its quality of care objective, BCBSM has developed and will conduct a patient satisfaction survey to assess member satisfaction with ASF services. Most recently, BCBSM solicited provider input from the ASF Liaison Committee regarding the survey BCBSM intends to distribute to assess member satisfaction with ASFs. BCBSM revised some of the questions in direct response to the input it received.

BCBSM is reminded that it is to routinely provide a copy of the approved minutes of ASF Liaison Committee meetings to OFIR.

COST GOAL

The Commissioner found in his determination report of October 12, 2009 that BCBSM's ASF provider class plan did not achieve this goal during the 2-year period under review but BCBSM's failure to achieve the cost goal was reasonable because of factors beyond BCBSM's control that impacted its ability to contain costs within the constraints of the cost goal specified in the Act. Factors beyond BCBSM's control include an aging population and the overall health status of Michigan residents. As Michiganders are living longer because of the development of cutting-edge technologies in medical diagnosis and treatment and due to the significant advances made in prescription drug therapy used to treat chronic conditions, the costs associated with these needs are disproportionately high. Also, the Baby Boomer generation, as it ages, has demonstrated its desire more so than any generation before them to be healthy, stay healthy, and to be fixed when they aren't healthy, whether the fix requires surgery or medication. Thus, increased use of surgical services and prescription medication continue to be a major driver of higher health care spending, providing a reasonable explanation as to why BCBSM had difficulty in achieving the cost goal. As such, BCBSM was not requested to revise any aspects of its reimbursement methodology. The Commissioner has reviewed BCBSM's ASF remedial provider class plan and has concluded that the rewritten plan continues to contain a reimbursement methodology designed to provide equitable

reimbursement to ASF providers for covered services and strives to achieve this goal.

The Surgery Center of Kalamazoo and the Michigan Ambulatory Surgery Association (MASA) expressed concern that although community based pricing has created a common fee schedule for ASFs and hospitals, if a hospital is harmed by fees it can petition BCBSM to raise its inpatient rates. BCBSM contends that this misrepresents the community based initiative. Hospitals received a one-time adjustment to inpatient rates when the initiative was implemented. This one-time adjustment transferred from the outpatient setting to the inpatient setting payment for the extra costs a hospital incurs (24/7 availability, graduate medical expenses, the costs of accepting all patients). Although it is true that BCBSM has a negotiation process with individual hospitals, it is not designed to have inpatient rates absorb "losses" from outpatient fees. BCBSM states hospitals are expected to provide outpatient services at the same community rate as non-hospital providers.

A few ASF providers state that BCBSM designed its fee setting methodology without provider discussion, transparency or benchmarking. BCBSM contends this is not accurate. BCBSM clearly stated its use of Medicare fees as a benchmark and explicitly reviewed the mechanics of the process with the committee members. BCBSM states it provided ASFs with specific data on the effects of the proposed changes, refined its benchmarking over time based on the ASF Liaison Committee's input and stated BCBSM's goal relative to what percentage above Medicare it believes its fees should be. BCBSM does not seek the approval of providers, whether it be ASFs or hospitals, when finalizing its outpatient surgery fees. BCBSM recognizes that some ASF Liaison Committee members have repeatedly stated BCBSM's fees do not cover their costs. BCBSM believes, however, that these arguments are not based on the cost of treating BCBSM members but instead are based on losses from governmental payers. The Act does not obligate BCBSM to cover the losses from other payers and BCBSM should not be expected to do so.

ASF providers also have expressed their desire to receive BCBSM payments via electronic fund transfers in lieu of a paper check and explanation of benefits. BCBSM is in the process of evaluating whether electronic fund transfers can be made available to all facility based providers. BCBSM expects to complete its analysis by September 30, 2010.

It is important for BCBSM to provide equitable reimbursement to ASF providers in order for there to be adequate access to, and quality of, medically necessary services. All ASFs, whether they are independently owned or hospital based, receive the same reimbursement for the same services. This is clearly an equitable reimbursement methodology. BCBSM uses Medicare fees as its

benchmark. BCBSM initiated an evaluation of its entire outpatient surgery fee schedule (common to hospitals and ASFs) based on input from providers on the ASF Liaison Committee. Providers had noticed that BCBSM's fees were not balanced as the fees for some procedures were too high while others were too low. As noted in the discussion on quality of care goal, based on input received from ASFs, BCBSM has adjusted its fee schedule to eliminate inequities across procedures on a budget neutral basis.

ORDER

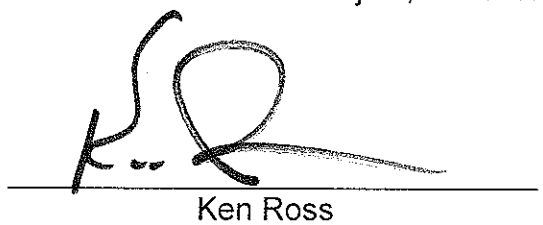
Therefore, it is ORDERED that:

1. The ambulatory surgical facilities provider class plan as filed by BCBSM on April 8, 2010 substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner in the October 12, 2009 determination report. The plan is therefore retained and placed into effect, as provided by Section 506 of the Act.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of the Commissioner's determination in this matter by certified or registered mail.

3. Appeals may be filed pursuant to Section 515 of the Act. Any request for such appeal shall be made within 30 days after receipt of the notice, as given under Section 513(3) of the Act.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary, and appropriate.



Ken Ross
Commissioner